

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County GarrettCity or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)Street No. -----
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Cora D. Bishop

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Charles Y. Bishop

6. (c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.) September 17, 1869

8. AGE:

Years

75

Months

6

Days

28

If less than one day

----- hrs. ----- min.

9. Birthplace Fairmont, W. Va.

(Town, county, and state)

10. Usual occupation House Wife11. Industry or business Own Home12. Name Michael Comerford13. Birthplace Ireland14. Maiden name Rachel Fleming15. Birthplace Fairmont, W. Va.16. Informant Margaret BerghausAddress Mt. Lake Park, Md.17. Burial April 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fleming CemeteryLocation Oakwood Road; Fairmont, W. Va.18. Funeral director Herbert P. Leighton
Address Oakland, Maryland.19. 4-15-45 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1945 4:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1942 to April 14 1945
and that I last saw him alive on April 11 1945

Immediate cause of death

Tuberculosis, Bone

DURATION

Due to -----

Due to -----

Other conditions Hypertrophy of Atria

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work?

23. SIGNATURE L. D. Baumgartner M.D.Address Oakland, Md. M. D. or otherDate signed 4/15/45

RECEIVED

MAY 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03975

Reg. Dist. No. 162

1. PLACE OF DEATH:

County... GarettCity or town... R.D.2 Grantsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... GarettCity or town... Rural Near Jennings
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Elmira Bittinger

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
--------------------	------------------------------	---

B.(b) Name of husband or wife... Jessie BittingerB.(c) If alive, give age. 52 years7. Birth date of deceased (mo., day, yr.) December 11- 1860

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>4</u>	<u>11</u>hrs.min.

B. Birthplace Rural Near Jennings Md
(Town, county, and state)10. Usual occupation... House Work

11. Industry or business

12. Name... John Bittinger13. Birthplace Rural Near Jennings Md14. Maiden name... Mary Spiker15. Birthplace Not Known16. Informant... Jessie BittingerAddress R.D.2 Grantsville Md17. Burial Date thereof... 4-24- 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... HooverLocation... Near Jennings Md18. Funeral director... Wm WinterbergAddress Grantsville Md19. April 23, 45 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 22 1945, at 3:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Apr 22 1945
and that I last saw him alive on Apr 1 1945Immediate cause of death Chronic Myocarditis DURATION

Due to.....

Due to.....

Other conditions... Diabetic Mellitus

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address... Grantsville Md Date signed Apr 23 1945

KIMBLY
APR 27 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

Reg. Dist. No. 03976 162

1. PLACE OF DEATH:

County GarettCity or town Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State MD County GarettCity or town Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Gilead Broadwater

3. (b) Social Security Number

None4. Sex M5. Color or race W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Ada Florence Broadwater

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 26- 18558. AGE: Years 89 Months II Days 14 If less than one day _____ hrs. _____ min.9. Birthplace R.D.2 Grantsville Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William C. Broadwater13. Birthplace R.D.2 Grantsville Md14. Maiden name Jane Warnick15. Birthplace R.D.2 Grantsville Md16. Informant Mrs Mary LivengoodAddress Grantsville Md17. Burial Date thereof 4-12-1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Wm. McIntoshAddress Grantsville Md19. April 11, 1945 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 45 8:30 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 45 to Apr 10 19 45 and that I last saw him alive on Apr 9 19 45Immediate cause of death Chronic Hypertension DURATION 2 yrs

Due to _____

Due to _____

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE N. B. Davis M.D. M. D. or otherAddress Grantsville Md Date signed Apr 11, 1945

UNITED STATES DEPARTMENT OF HEALTH

INSTITUTE OF HEALTH

RECEIVED

APR 23 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 722

CERTIFICATE OF DEATH

03977
Reg. Diat. No. 162

1. PLACE OF DEATH:

County... Garett
 City or town... Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Garett
 City or town... Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Myrtle Estella Broadwater

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Nevin Broadwater6. (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.)

April 12 1896

8. AGE:

Years

48

Months

11

Days

24

If less than one day

hrs.

min.

9. Birthplace

R.D.I. Accident Md
(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

FATHER
MOTHER

12. Name

F. Josephus Clotfelty

13. Birthplace

R.D.I. Accident Md

14. Maiden name

Elizabeth Spiker

15. Birthplace

R.D.I. Accident Md

16. Informant

Nevin Broadwater

Address

Grantsville Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4-8-1945

(month) (day) (year)

Cemetery or crematory

Grantsville

Location

Near Grantsville Md

18. Funeral director

Wm Wintberg

Address

Grantsville Md

19.

April 7 1945
(Date rec'd by registrar)Elder Broadwater

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 5 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 5 1945 to Apr 5 1945
and that I last saw him alive on Apr 5 1945

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. Davis M.D.

M. D. or other

Address

Grantsville Md

Date signed

Apr 5 1945

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

APR 23 1945

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

03978

Reg. Dist. No. 168

1. PLACE OF DEATH:

County GarrettCity or town Finzel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel Finzel Brown

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Wm. Brown

7. Birth date of deceased (mo., day, yr.)

April 14, 1868

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

77100

.....hrs.

.....min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

housewife

11. Industry or business

home

FATHER

12. Name

Charles L. Golden

13. Birthplace

Maryland

MOTHER

14. Maiden name

Columbia Deckatree

15. Birthplace

Maryland

16. Informant

Mrs. Howard Wagner

Address

Finzel, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof April 16, 1945
(month) (day) (year)

Cemetary or crematory

Finzel Cemetery

Location

Finzel Md.

18. Funeral director

J. J. Quirist

Address

Frostburg Md.

19.

(Date rec'd by registrar)

April 14, 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Garrett

City or town

Finzel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 14

19.45

at

4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19

19.43

to

4/14

19.45

and that I last saw him

alive on 4/13

19.45

Immediate cause of death

Chronic heart failure

DURATION

2 mo

Due to

Cardiovascularrenal disease

Due to

Generalized Arterio-sclerosis

Other conditions

Diabetes mellitus2 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistics by.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Hilda J. Quirist

M. D. or other

Address

Frostburg Md.

Date signed

4/14/45

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APR 26 1945

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

03979

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Joseph Charles Eggers.

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

B.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th, 1863.

8. AGE:

Years

Months

Days

If less than one day

81924

.....hrs.min.

9. Birthplace Oakland, Maryland.
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Henry John Eggers.13. Birthplace Germany.14. Maiden name Margaret Shaffer15. Birthplace Germany.16. Informant Miss Annie Eggers.Address Oakland, Maryland.17. Burial Date thereof May 3d, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peters Cemetery.Location Oakland, Maryland.18. Funeral director Enroy D. Bolden.Address Oakland, Maryland.19. 5-2-45 Julia Pomeroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th, 1945 at 4:40 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from P.M.
Apr. 21 1945 to Apr. 30 1945
and that I last saw him alive on April 30 1945Immediate cause of death Coronary Heart DiseaseDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Baumgartner M.D.Address Oakland Md Date signed 5/1/45

RECEIVED
MAY 7 1945
BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 3980

1. PLACE OF DEATH

County GarretteVillage or City Friendsville, R.F.D

No.

Registration Dist. No. 168

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Mervin Paul Frazee,

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>(write the word)</i> <u>Single</u>
-----------------------	----------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofSingle

6. DATE OF BIRTH (month, day, and year)

April 24 1933

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.IIII8

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Student9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.Grammar School10. Date deceased last worked at
this occupation (month and
year)3-30-4511. Total time (years)
spent in this
occupation 6 yrs

12. BIRTHPLACE (city or town)

Friendsville, R.F.D.

(State or country)

Garrette Co Md,FATHER
MOTHER

13. NAME

Jermiah Frazee

14. BIRTHPLACE (city or town)

Friendsville,

(State or country)

Garrette Co, Md,

15. MAIDEN NAME

Pauline Friend,

16. BIRTHPLACE (city or town)

Garrette Co, Md,

(State or country)

17. INFORMANT

Jeremiah Frazee

(Address)

Friendsville, Md,

18. BURIAL, CREMATION, OR REMOVAL

Place Burial

Date

April 4, 1945

19. UNOERTAKER

E. G. Harned

(Address)

Brandonville, W. Va,

20. FILED

April 4, 1945 Sea Church,

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

April 2 1945 1945
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from
Feb. 10, 1945, to April 2, 1945I last saw him alive on March 27, 1945; death is saidto have occurred on the date stated above, at 2:15 P.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Congestive Heart Failure
which was caused by a
rheumatic heart disease which
was caused by focus of
infection in tonsils.

Osteoplasia

Other Contributory Causes of importance:

~~XXXXXXXXXXXXXXXXXXXX~~

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

H. X. G. Love
Friendsville, Maryland

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel, etc.* For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as *spinner, weaver, etc.*

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill, etc.*

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer, etc.* Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as *carpenter, painter, machinist, etc.* Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for addition of usual residence of deceased is shown on **STATE OF MARYLAND—CERTIFICATE OF DEATH**

03981

1. PLACE OF DEATH

County GarretteVillage or City Friendsville, R.F.D.

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Playford Friend(a) Residence: No. Friendsville, Maryland, R.D. St. _____ Ward. _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofSusan M Lodermilk

6. DATE OF BIRTH (month, day, and year)

Nov 20 1881

7. AGE

Years

63

Months

4

Days

29If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Farmer9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.Own Farm10. Date deceased last worked at
this occupation (month and
year)194511. Total time (years)
spent in this
occupation63

12. BIRTHPLACE (city or town)

(State or country) Garrette Co Md.

FATHER

13. NAME

Taylor Friend

MOTHER

14. BIRTHPLACE (city or town)

(State or country) Garrette Co Md.

15. MAIDEN NAME

Elizabeth Feathers,

16. BIRTHPLACE (city or town)

(State or country) Preston Co W. Va.,

17. INFORMANT

(Address)

Robert Louchmilk
Friendsville, MD.

18. BURIAL, CREMATION, OR REMOVAL

Place Sandsprings Cemetery Date Apr 22, 1945

19. UNDOERTAKER

(Address)

E. G. Harned
Brandonville, W. Va.,

20. FILED

4/21

1945

Ira C. Rusk
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

April

(Month)

19

(Day)

1945

(Year)

22.

I HEREBY CERTIFY. That I attended deceased from

Apr-19- 1945 to Apr-19- 1945I last saw him alive on Apr-19- 1945; death is said
to have occurred on the date stated above, at 8:10 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Coronary Occlusion

Date of onset

4-19-45

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

H. B. Mansmore

M. D.

(Address)

Addison Pa

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of **MARYLAND STATE DEPARTMENT OF HEALTH**
sex & color of deceased is shown on 2411 N. Charles St., Baltimore 270

FILM No. G 95 MAY 28 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:
County... **Garrett**
City or town... **Mt. Lake Park**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **1 year**
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... **W. Va.** County... **Tucker**
City or town... **Davis**
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Fredrick Dixon Golightly

3.(b) Social Security Number

4. Sex Male **5. Color or race** White **6.(a) Single, married, widowed, or divorced**

6.(b) Name of husband or wife **Norrene Hostetler Golightly**

7. Birth date of deceased (mo., day, yr.) **Feb. 4, 1901** **6.(c) If alive, give age** **34** years

8. AGE: Years **44** Months **2** Days **17** If less than one day
.....hrs.min.

9. Birthplace **Davis, Tucker, W. Va.**
(Town, county, and state)

10. Usual occupation **Merchant and Post Master**

11. Industry or business

12. Name **Wm. W. Golightly**

13. Birthplace **Winchester, Va.**

14. Maiden name **Mary E. Shreve**

15. Birthplace **Upper Tract, W. Va.**

16. Informant **Mrs. Norrene Golightly**

Address **Davis, W. Va.**

17. Burial **April 22, 1945**
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium **Davis**

Location **Davis, W. Va.**

18. Funeral director **L. H. Mott**

Address **Davis, W. Va.**

19. Apr 21, 45 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **April 21, 1945** at **1:45A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **4-5-45** **4-21-45**

and that I last saw him alive on **4-20-45**

Immediate cause of death **heart attack**

Other conditions **Progressive Multiple Sclerosis**

Other conditions **years**

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Date of**

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury **Injured at work?**

23. SIGNATURE **Edward E. Shaw**

Address **Oakland, Md.**

Date signed **4/21/45**

HEALTH DEPARTMENT OF HEALTH

CENTRAL OFFICE OF HEALTH

REPORT OF DEATH

REPORT OF DEATH

RECEIVED
MAY 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03983

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County County.
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas A. Gonder.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.
 6.(b) Name of husband or wife Mrs. Annie West Gonder.
 6.(c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) November 28th, 1883
 8. AGE: Years 61 Months 4 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Oakland, Maryland.
 (Town, county, and state)
 10. Usual occupation Druggist.
 11. Industry or business _____
 12. Name Andrew B. Gonder.
 13. Birthplace Cumberland, Maryland.
 14. Maiden name Mary Martha Casteel.
 15. Birthplace Garrett County, Maryland.

16. Informant Mr. W. A. Gonder.
 Address Oakland, Maryland.
 17. Burial Date thereof April 19/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Episcopal Cemetery.
 Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.
 Address Oakland, Maryland.
 19. 4-18-45 Julia Rowan
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1945, at 6:30 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from P.M.
April 14 to April 16 1945
 and that I last saw him alive on April 16 1945
 Immediate cause of death Carcinoma of prostate
with metastasis DURATION _____
 Due to _____
 Due to _____
 Other conditions Myocarditis
neuropathy
 (Include pregnancy within 3 months of death)
 Major findings of operations Carcinoma prostate metastasis
to bone, prostate removed Date of op. Apr 1944
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work?

23. SIGNATURE R. D. Baumgartner M.D.
Dalton M. D. or other _____
 Address _____ Date signed Apr 18-1945

RECEIVED

MAY 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County... GarrettCity or town... Deer park, Maryland.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... GarrettCity or town... Deer Park
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mildred Garnett Minard.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) August 7th 19138. AGE: Years Months Days If less than one day
31 8 7 hrs. min.9. Birthplace Deer Park, Md.
(Town, county, and state)10. Usual occupation... House maid

11. Industry or business

12. Name... Ernest McRobie.13. Birthplace Garrett County, Md.14. Maiden name... Lillian Minard.15. Birthplace Garrett County, Md.16. Informant... Lillian Minard.Address Deer Park, Md.17. Burial Date thereof April 17th/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Deer Park Cemetery.Location... Deer Park, Md.18. Funeral director... Emroy D. Bolden.Address Bakland, Maryland.19. 4-16-45 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 4-14-45 19... at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-1-42 19... to 4-14-45 19...
and that I last saw him er alive on 4-13-45 19...Immediate cause of death... Mumps

DURATION

3 daysDue to... Heart Lesion and Epileptic fits all of 1
life

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Edward E. Rowan

M. D. or other

Address... Oakland, Md. Date signed 4-18-45

UNITED STATES DEPARTMENT OF HEALTH

AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY

FOR HEALTH POLICY AND PROGRAMS

WASHINGTON, D.C. 20492

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TELETYPE (202) 205-4000

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MUSEUM SERVICES (202) 205-4000

THEATRE SERVICES (202) 205-4000

CINEMA SERVICES (202) 205-4000

MUSIC SERVICES (202) 205-4000

RECEIVED

MAY 7 1965

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 03985 166

1. PLACE OF DEATH: Garrett
 County.....
 City or town..... Hutton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland..... County..... Garrett
 City or town..... Hutton, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, gave war.....

3. (a) FULL NAME

Joseph M. Pendergast.

3. (b) Social Security Number

None

4. Sex..... Male..... 5. Color or race..... White..... 6.(a) Single, married, widowed, or divorced..... Single.
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 10th, 1876.
 8. AGE: Years..... 69..... Months..... 8..... Days..... 22..... hrs..... min.....

9. Birthplace..... Hutton, Maryland.
 (Town, county, and state)

10. Usual occupation..... Farmer.

11. Industry or business

FATHER 12. Name..... Martin Pendergast.
 13. Birthplace..... Ireland.

MOTHER 14. Maiden name..... Margaret Shaffer.
 15. Birthplace..... Germany.

16. Informant..... Mr. Wm. R. Pendergast.
 Address..... Hutton, Maryland.

17. Burial..... Date thereof..... April 4th/45.
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... St. Peters Cemetery.
 Location..... Oakland, Maryland.

18. Funeral director..... Emroy D. Bolden.
 Address..... Oakland, Maryland.

19. 4/3/..... 19 45 Julius Rower
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2d, 1945..... 19..... at..... 5:30..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... A.M.
 19..... to..... 19.....
 and that I last saw undead Apr 2 at 10 am..... 19 45

Immediate cause of death..... Heart Attack..... DURATION.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... M. C. Hinebaugh..... M. D. or other.....
 Address..... Oakland..... Date signed..... 4/2/45

RECEIVED

MAY 7 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH:

County GarrettCity or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 yrs.

Hospital, institution, or street address where death occurred:

Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)Street No. Race Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Ruth Alice Scisci

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Carlo Scisci6.(c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.)

July 7, 1882

8. AGE:

Years

52

Months

8

Days

23

If less than one day

.....hrs.min.

9. Birthplace

Swallow Falls, Garrett Co., Md.

(Town, county, and state)

10. Usual occupation

HouseworkOwn Home

11. Industry or business

FATHER

12. Name

Philip Lewis

13. Birthplace

Oakland, Md.

MOTHER

14. Maiden name

Lydia Spiker

15. Birthplace

Near North Glade, Garrett Co., Md.

16. Informant

Address

Miss Rose ScisciKitzmiller, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 3, 1945

(month) (day) (year)

Cemetery or crematory

Friend Cemetery

Location

Swallow Falls, Garrett Co., Md.

18. Funeral director

Address

Otha F. SharplessBlaine, W. Va.

19. May 1 1945

(Date received by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 12:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1945 to April 30 1945
and that I last saw him ex alive on April 30 1945

Immediate cause of death

Cerebral embolism
Intestinal infarct

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cerebral embolism Intestinal infarct Date of op. April 4, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Ralph Culandrelli M.D. M. D. or other May 7, 45
Date signed

RECEIVED

MAY 22 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 164

03987

1. PLACE OF DEATH:

County GarrettCity or town Rural, Accident
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural, Accident, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carrie Emma Snyder

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Albert Snyder6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) July, 8, 1889.8. AGE: Years Months Days If less than one day
55 9 6 _____ hrs. _____ min.9. Birthplace Pemberville, Ohio.
(Town, county, and state)10. Usual occupation House Work

11. Industry or business

12. Name Louis Sander13. Birthplace Pemberville, Ohio.14. Maiden name Mary Stein15. Birthplace Pemberville, Ohio.16. Informant Albert SnyderAddress Accident, Md.17. Burial Date thereof April, 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Accident, Md.18. Funeral director Allen WinterbergAddress Grantsville, Md.19. April, 16, 1945 Registrar Emma C. Spierlein
(Date rec'd by registrar)

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH April, 14, 1945, at 3.30, AM.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10, 1944, to Apr. 14, 1945.and that I last saw him alive on Apr. 13, 1945.Immediate cause of death Carcinoma-Uterus DURATION 5-6 mo.

Due to _____

Due to _____

Due to _____

Due to _____

Due to _____

Due to _____

Other conditions Ovarian Cyst

(Include pregnancy within 3 months of death)

Major findings of operations Ovarian Cyst and Carcinoma UteriDate of op. 10-15-44

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE C. W. Sander M. D. or otherAddress Cumtland Md. Date signed 4-16-45

RECEIVED
APR 21 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 039886

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Md. Route #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Oakland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Raleigh Groves White.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Annie Lawton White
Deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 11 1854
 8. AGE: Years 91 Months 3 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Garrett County.
 (Town, county, and state)
 10. Usual occupation Retired Farmer.
 11. Industry or business _____
 12. Name William White
 13. Birthplace Garrett County.
 14. Maiden name Rachel Smith.
 15. Birthplace Garrett County.

16. Informant Mrs. Harry Durst.
 Address Oakland, Md, Route #1.
 17. Burial Date thereof April 26th/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oakland Cemetery.
 Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.
 Address Oakland, Md.

19. 4-26-45 Julia A. Rozen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April- 24- 1945 19____ at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-7-44 19____ to 4-24-45 19____
 and that I last saw him alive on 4-17-45 19____

Immediate cause of death Heart attack DURATION _____

Due to Art. eroposclerosis
and softening of the base of brain.
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Edward D. Bolden M. D. or other _____
 Address Oakland, Maryland Date signed 4-25-45

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MAY 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

Reg. Dist. No. 03989 166

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Bernard Wilson.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife _____
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) November 16th, 1944
8. AGE: Years 0 Months 5 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Maryland.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Carl Wm. Wilson.

13. Birthplace Oakland, Maryland.

14. Maiden name Ruth Martin.

15. Birthplace Crellin, Maryland.

16. Informant Mrs. Ruth Wilson.

Address Oakland, Md.

17. Burial Date thereof Apr 24/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery.

Location Oakland, Md.

18. Funeral director Emroy D. Bolden.

Address Oakland, Maryland.

19. H-23-45 Julia Raven
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22d, 1945 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AM
4 minutes after death 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death: Asphyxia

Due to Accidental suffocation, while in bed.
Caused.

Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 4/22/45
Accident, suicide, or homicide. Accident Date of 4/22/45
Where did injury occur? Oakland Garrett Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home
Means of injury Asphyxiation Injured at work? No

23. SIGNATURE E. J. Bampton and Hammer.
M. D. or of Dr. J. M. D.
Address Oakland Md Date signed 4/23/45

RECEIVED

RECEIVED

MAY 7 1945

BUREAU V.S.

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